Health and Human Services Commission
Hospital Payment Advisory Committee

February 9, 2017
Meeting Minutes

Members Present:
William Galinsky, Chair
Phillip Caron
Steven Hand
Rebecca McCain
Diana Strupp
Michael Nunez
Bill Bedwell
Stephen Kimmel
Sharon Clark
Alec King
Eric Hamon

Members Absent:
Timothy McVey, Vice Chair
Dan Olvera

1. **Opening comments: William Galinsky, Hospital Payment Advisory Committee Chair**

Bill Galinsky called the meeting to order at 1:40 pm and based upon the members in attendance, a quorum was present.

2. **Approval of February 11, 2016, and May 5, 2016, meeting minutes.**
Diana Strupp motioned for approval.
Michael Nunez seconded the motion.
The motion to approve the minutes passed unanimously.

Gary Young briefly reported the Legislature is in session and is considering a number of activities which will affect the Texas Medicaid Program and healthcare finance in general.

NOTICE OF INFORMATIONAL ITEMS:

3. **General Provisions**

The Texas Health and Human Services Commission (HHSC) proposes in Texas Administrative Code (TAC) Title 1, Part 15, Chapter 353, new Subchapter O, relating to Delivery System and Provider Payment Initiatives, and new § 353.1301, relating to General Provisions. This proposed new rule describes certain general provisions which apply to all Medicaid managed care delivery system and provider payment initiatives, or directed payments. As part of the recent overhaul of federal Medicaid Managed Care (MMC) rules, the Centers for Medicare & Medicaid Services allowed states which operate MMC to direct Managed Care Organization (MCOs) payments to providers. This rule describes provisions HHSC considers to be universal to all such directed payment programs which are or will be implemented in Texas.

Steve Kimmel asked for clarification of the 10% amount added for intergovernmental

transfers (IGTs) and an explanation of how it is used. Ms. McDonald explained Managed Care Organizations are paid for member months. A capitation rate is set and for each month a managed care organization provides service for a member, they are paid the capitation rate. A "bump" is included to increase the capitation rate for special programs. The Uniform Hospital Rate Increase programs are part of this. Part of the money paid is federal and part is non-federal; the non-federal funds are IGT. Member month payments are tracked and the 10% is used to cover any shortfall due to member months exceeding their forecast level. If money is needed to cover additional member months, it is paid out, if it is not needed it remains in the fund. Any monies remaining from the 10% at the time reconciliations are made are returned to the IGT entity it originated from.

Sharon Clark questioned if consideration had been given to moving the disallowance provision back to the beneficiaries. Ms. Clark expressed concern undue burden may be put on public entities creating an IGT making it difficult to find participants.

HHSC Staff Attorney Monica Leo stated there has been heightened scrutiny by CMS of the underlying funding arrangements for private hospitals. HHSC's Rate Analysis Office considered the program and the potential that CMS might look at some of the underlying funding arrangements and find something that they considered to be an impermissible arrangement. HHSC considered how recoupment might differ from recoupment in other circumstances. CMS perceives the governmental entity which received the alleged donation has not really expended any public funds because these are private funds given to them by the private hospitals and the public entity turns around and transfers the funds to HHSC. The perception of CMS is only federal funds and private funds have gone into the payment, no public funds have gone in. If HHSC were to recoup a payment directly from a provider then the donation problem is exacerbated because a private entity is giving funds to the public entity which is supposed to be providing the non-federal share of the payment. In the context of these payments which flow through managed care organizations, it becomes even more complicated, because HHSC is using the IGT that is transferred to HHSC as the non-federal share of a component of the cap rate previously mentioned. HHSC is then making a payment to an MCO and the MCO is making a payment to a hospital. HHSC would welcome thoughts about a legal avenue to do something different than to recoup those funds from a public entity. HHSC feels this is an important consideration for the participants in the program.

Bill Bedwell asked what other disallowances HHSC sees happening. Ms. Leo responded saying CMS could come in and look at new programs especially if they felt something was not consistent with approvals HHSC had received from CMS. CMS has to approve contracts and is approving templates submitted for each service delivery area. A CMS conclusion that some payments HHSC had made were inconsistent with their approval of either the contracts or the templates could be the basis of a disallowance.

Michael Nunez questioned if it is a correct statement that HHSC would return the IGT used to fund the overpayment back to the governmental entity which initially provided the public funds. Pam McDonald confirmed if HHSC recoups an overpayment which was supported by IGT, HHSC returns the federal share back to the federal government entity and the non-federal share back to the governmental entity(s) which provided the IGT

4. Regional Uniform Rate Increases for Hospital Services

HHSC proposes new §353.1305, relating to Regional Uniform Rate Increases for Hospital Services, in TAC Title 1, Part 15, Chapter 353, new Subchapter O. The proposed new

section describes the circumstances under which HHSC will direct a Medicaid MCO to provide a uniform percentage rate increase to hospitals in the MCO's network in a participating Service Delivery Area (SDA) for the provision of inpatient services, outpatient services, or both. This section also describes the methodology used by HHSC to determine the percentage rate increase.

In light of recent federal regulation and with the goal of enhancing care coordination and achieving better health outcomes, this proposed rule authorizes HHSC to use inter-governmental transfers from non-state governmental entities or from other state agencies to support capitation payment increases in one or more SDAs. Each MCO within the SDA would then be contractually required by the state to increase hospital payment rates by a uniform percentage for one or more classes of hospital which provide services within the SDA.

Michael Nunez questioned the timing of the IGT and asked if there has been any further discussion regarding the funding of the second 6 months. He noted from the public hospital perspective, the November to December timeframe represents the lowest cash balances of the year. Mr. Nunez requested HHSC consider spreading IGT requirements out the second half of the year, achieving smaller increments more frequently as opposed to one large installment. Pam McDonald agreed there are a number of ways to approach the second increment. The first option for HHSC would be to collect all money in a lump sum in November. The preferred second option is to collect monies on a monthly basis beginning in June. HHSC appreciates input from hospitals and acknowledges hospitals do have cash flow issues.

Diana Strupp requested an explanation of the subset clause. Ms. McDonald explained the preference of HHSC is the percentage increase be across the board, either all in-patient services, all in-patient and out-patient services or all out-patient services. If an SDA wants to bring forward a subset, the rule allows HHSC to review and consider it.

Bill Galinsky questioned if a uniform rate increase were given, wouldn't the fact they are already paid at a lower rate and would get a uniform percentage increase still keep them at a lower rate and reduce the need to try to keep the language perpetuated. Ms. McDonald agreed it would definitely have them at a lower rate than all of the other services. The Legislature gives HHSC direction indicating they would not be pleased with increased payments for those services. HHSC is open to comments.

Eric Hamon questioned if there is not consensus in SDA between one or more MCOs or one or more providers, what is the role of HHSC. Ms. McDonald replied HHSC does not want to function as peacemaker or mediator for an SDA. HHSC wants the SDAs to come together with a proposal and it is to everyone's advantage the proposal developed in the SDA is one the MCOs can live with. What is in the contract with HHSC and its MCOs is influenced by both parties, every MCO and SDA gets the same rate, none of them can be left out, none can have a different percentage rate increase. Community rates are set for the MCOs and SDAs. If there is severe dissension within an SDA. HHSC expects hospitals, IGTs and MCOs make

a good faith effort to come together with a proposal. The program according to CMS regulations, is approved on an annual basis, HHSC evaluates the program, CMS then decides if they will approve it for another year. Ms. McDonald stated HHSC wants to be cautious in rolling out a new program where it does not know the unintended effects of what may happen. The commission's position will be to leave it up to the SDAs to work things out.

Eric Hamon questioned if the proposed rule allows for the providers and the MCOs to pay some doctors to prevent cases from going to emergency rooms with an enhanced payment through quality incentives. Ms. McDonald stated the manner in which the CMS rule is written allows HHSC to direct their MCOs to do a uniform percent rate increase. Contracts with MCOs will spell out that MCOs are to pay a class of hospitals a percentage of the base rate which would otherwise be paid to the hospital. Ms. McDonald feels there would not be a lot of flexibility. This does not mean the non-directed dollars could not be used between the MCOs and the hospitals. Eric Hamon questioned if is it standard practice for MCOs to provide rate enhancements to providers to reduce in-patient stays or costs. Ms. McDonald agreed it could be in the base rate negotiations. HHSC is trying to maintain simplicity in order to execute.

Steve Hand asked for clarification as to which programs would be competing with budget neutrality limits. Ms. McDonald responded that the programs are the uniform percentage rate increase for hospitals, QIPP, NIPS, and NAIP. Mr. Hand questioned when and by what means had HHSC received communication stating IGT commitments were unacceptable. Ms. McDonald responded that HHSC received a letter from CMS approving STAR+PLUS managed care rates in which CMS said they would approve this time, but would not approve managed care rates which have the underlying agreement again in the future. In response to a question from Michael Nunez, Pam McDonald clarified the uniform rate increase application is an informational to help determine the rates, but not an enforceable.

Bill Galinsky asked if there could there be any consideration for a one-time exception to the advance funding, related to funding legislation which is in the pipeline (as the legislature is still in session). He clarified he was speaking specifically of local provider participation funds (LPPF) in markets where they do not currently exist. Ms. McDonald noted the request could be very problematic as HHSC does not have flexibility in the timeline for determining the capitation rates.

Rebecca McCain questioned if the definitions from the DSHS program are the same as from DSRIP and noted the hospital she is employed by falls into two of the definitions, creating confusion. Ms. McDonald said they are not and acknowledged there is overlap in some groups. She expressed HHSC would appreciate receiving comments related to the overlap, to allow creation of a hierarchy.

Testimony:

Richard Schirmer, Vice President Health Care Policy Analysts, Texas Hospital Association, spoke in support of Agenda Item 4.

Mr. Schirmer commented on four specific areas.

- **Hospital Reliance on Medicaid.** Many hospitals in Texas rely on Medicaid to serve a

vulnerable population. Medicaid payments account for approximately 14% of hospital payments and about 19% of hospital discharges. Medicaid base rates are low and currently cover about 60% of costs. Hospitals have to rely heavily on supplemental payments. The IGT amounts are almost as much as what is paid out for hospital inpatient payments. Any rate enhancements will provide additional financial stability especially when considering the uncertainty of the future of Medicaid and the 1115 waiver. Flexibility is the key and local provider rate enhancements will be a crucial part of the flexibility.

- **Implementation Timeframe.** Mr. Schirmer recommended the rule be implemented in an expeditious manner. Two of the potential benefits concern improved care coordination for patients and better health outcomes.

- **Timeliness of IGT.** Currently the IGT payment has to be put up in May. Sixteen months is a long time for the public hospitals to have the payments outstanding. The hospitals have to put up two IGTs, one in May and then again 6 months later. The need to simplify the IGT amounts and establish the (per member per month) PMPM rates is understood; however, there should be a way to establish a commitment where no money is transferred and the money is finally transferred closer to the beginning of the fiscal year. Transfer amounts are to cover the costs of the program plus 10%. Mr. Schirmer questioned if it would be better to establish more frequent payments rather than making one large IGT payment.

- **Payment Reconciliation Process.** The Nursing Facility Minimum Payment Amounts Program (MPAP) has had funds go through the MCOs and there have been problems with the encounters data required to finalize payments. Mr. Schirmer recommend HHSC establish a process to ensure data is correct and payment reconciliations are done in an expeditious manner.

Mr. Schirmer said the Texas Hospital Association is asking members for their input and in summary stated Texas Hospital Association supports the proposal as it allows hospitals to draw down much needed federal dollars.

5. **Public Comment.**

No additional public comment was received.

6. **Proposed next meeting: June 8, 2017, at 1:30 p.m.**

7. **Meeting Adjourned.**